U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
2370 Route 70 West
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

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Case No. 2001-BLA-00798

In the Matter of

BETTY WENTZ (widow of JOSEPH WENTZ)
Claimant

v.

WEST PAVING COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Carolyn M. Marconis, Esq.
For the Claimant

A. Judd Woytek, Esq.
For the Employer

Before: PAUL H. TEITLER
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for survivor's benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the

meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of their death. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

Claimant requested a hearing before this Office on February 22, 2001 (DX 19) following the denial on December 28, 2000 by the Director, Office of Workers' Compensation Programs (OWCP) on Claimant's application for survivor's benefits filed on August 2, 2000 (DX 1, 16).

Procedural History

Claimant's husband filed a claim for benefits on February 9, 1977. His claim was initially denied on May 10, 1977, and then denied again following reconsideration on April 17, 1981 (DX 26). Following the miner's death on September 26, 1998, his widow filed a claim for survivor's benefits on August 2, 2000 (DX 1).

Applicable Law:

Entitlement to benefits must be established under the regulatory criteria at Part 718 for this survivor's claim filed on August 2, 2000. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). Section 718.205(a)[1] provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis which arose out of coal mine employment. An eligible survivor will be entitled to benefits if claimant proves that: 1) The miner had pneumoconiosis; 2) The miner's pneumoconiosis arose out of coal mine employment; and 3) The miner's death was due to pneumoconiosis as provided by this Section. For purposes of claims filed after January 1, 1982, death will be considered due to pneumoconiosis if any of the following criteria is met: 1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; or 2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death; or 3) Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable. 20 C.F.R. 718.205(c). The regulations also provide that survivors are not eligible for benefits where the miner's death was caused by a

[1] Citations are to the "new" regulations published at 65 Federal Register 79920-80107 under Title IV of the Federal Coal Mine Health and Safety Act of 1969 as amended, 30 U.S.C. §§ 901-945. In an Order dated July 19, 2001, I found the new regulations would not affect the outcome of this case and, thus, the stay issued in the Preliminary Injunction Order, *Mining Associates, et al, v. Chao, et al,* No. 1:00CV03086 (February 9, 2001), was not applicable to this matter. Subsequently, Judge Sullivan granted the Department of Labor's motion for summary judgement and dissolved the Preliminary Injunction Order, *Mining Associates, supra,* (August 9, 2001).

traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. 718.205(c)(4). The regulations further provide that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. 20 C.F.R. 718.205(c)(5).

In its brief, dated December 20, 2001, Employer conceded that Claimant was the dependent survivor of the miner, Joseph Wentz, that the miner worked 18.5 years in coal mine employment and that the miner had pneumoconiosis. Claimant agreed it her brief that 18.5 years of coal mine employment had been established. Since the parties agree that the presence of pneumoconiosis has been established and since, as will be discussed in detail below, the evidence supports this stipulation, I adopt the stipulation that the deceased miner had pneumoconiosis at the time of his death on September 26, 1998. The only issue remaining before me is whether or not the miner's death was due to pneumoconiosis as provided by Section 718.205(c).

The record includes extensive medical reports documenting the miner's treatment over several years for various medical conditions. A statement accompanying records from Dr. P. Kleaveland indicates Dr. Kleaveland treated the miner for cardiac problems from 1994 through 1997. Some of these records reference the miner's pulmonary condition. A statement from Dr. Feldman in December, 1994 stated the risk of provoking a bronchospasm was small. The miner was hospitalized from December, 1994 through January, 1995, and was treated for his cardiac condition and a fracture. Another hospital report dated December, 1995 listed chronic obstructive pulmonary disease of questionable severity as one of many diagnoses. In February, 1996, pulmonary function studies showed evidence of a severe restrictive disease with marginal response to bronchodilator therapy. In May, 1996, Dr. Kleaveland wondered if some shortness of breath was due to cardiac medications, and he adjusted the miner's medications at that time. In a letter dated February 6, 1997, Dr. Kleaveland agreed the miner had lung disease which is severe. He stated he was not sure a cardiac catherization would make a difference in the miner's long term or immediate survival given the severity of the pulmonary problem (DX 12).

Records from Dr. Tavaria, the miner's treating physician, show the miner was hospitalized in December, 1994 to January, 1995 for treatment of syncope. Pneumoconiosis and chronic obstructive pulmonary disease were included as diagnoses in these reports. In 1996, the miner was seen by Dr. Ahluwalia who wrote to Dr. Tavaria in April and May of 1996. Dr. Ahluwalia noted exertional dyspnea on walking in the examination room, and he reported the miner had an emphysematous chest with increased AP diameter. Dr. Ahluwalia also reported severe airflow limitation and requested a CT scan to rule out the presence of neoplasm or carcinoma. In this report, Dr. Ahluwalia also stated that the miner may not be a candidate for treatment of carcinoma because of his pulmonary conditions. Following the CT scan on June 7, 1996, however,

Dr. Ahluwalia reported no underlying neoplasm. The CT report indicated the presence of extensive bullous emphysema in the left lung with consequent compression of surrounding left mid-lung parenchyma and prominent pulmonary vascularity without definite hilar or mediastinal mass. Dr. Ahluwalia diagnosed severe chronic obstructive disease (bullous emphysema), weight loss probably related to pulmonary cachexy, hypothyroidism by history, hypertension and coronary artery disease. Dr. Ahluwalia also reported the miner was being treated with home oxygen (DX 9, 10).

In December, 1996, the miner was hospitalized and a consultation report from Dr. Cable stated he was admitted with severe shortness of breath. Dr. Cable noted a history of severe emphysema, a long standing history of chronic obstructive pulmonary disease and coal workers' pneumoconiosis, a history of carotid artery disease, hernia repair and cataract surgery. Dr. Cable reported increased AP diameter, hyper-resonance to percussion and a respiratory rate of 50 with labored and breathing and marked use of the accessory muscles of respiration. Dr. Cable also reported marked prolongation of the expiration phase of respiration and diffuse wheezes on expiration. Because of the miner's breathing difficulties, Dr. Cable was not able to have him lay back for a more thorough physical examination. On chest x-ray, Dr. Cable reported emphysematic changes with large bulla in the lower left lung field. Dr. Cable's impressions included acute exacerbation of chronic obstructive pulmonary disease, emphysema, coal workers' pneumoconiosis, and cardiac arrhythmia (DX 11).

The miner was hospitalized again from December 27, 1996 though January 11, 1997 and treated for exacerbation of chronic obstructive pulmonary disease, bronchitis, respiratory failure secondary to the above diagnoses, emphysema, coal workers' pneumoconiosis, atrial fibrillation, hyperkalemia, non Q wave myocardial infarction, hypertension, coronary artery disease, sinus tachycardia, internal hemorrhoids, and ischemic colitis with lower GI bleed (DX 13). X-ray reports in July and September, 1998 indicated the presence of chronic obstructive pulmonary disease with large bulla in the left lung (DX 10).

The miner's final hospitalization was at Good Samaritan Hospital from September 19 through 26, 1998. A CT scan taken at that time showed right lung carcinoma with emphsyematic changes, metastatic disease to the liver, spleen and left adrenal gland. The miner was treated for pain and hospice options were explored. However, the miner deteriorated and died on September 26, 1985. The final diagnosis was: 1) carcinoma of the lung, 2) liver metastasis, 3) congestive heart failure, 4) chronic obstructive pulmonary disease, 5) hypertension, 6) coronary artery disease, 7) respiratory failures, and 8) old myocardial infarction (DX 13). Dr. Tavaria signed the death certificate which listed the miner's cause of death as respiratory failure due to cancer of the lung due to coal workers' pneumoconiosis (DX 8).

At a deposition taken on April 8, 1999, Dr. Tavaria, a board certified internist,

stated he had been the miner's treating physician since 1976. Dr. Tavaria stated the miner's main problem over the years was his shortness of breath which increased, was treated with oxygen and from which he eventually died. Dr. Tavaria stated it was not possible to treat the miner's lung cancer when it was discovered in September, 1998 because of his advanced lung disease. He further stated that if not for the underlying pneumoconiosis, the miner's lung cancer could have been treated and the miner's life could have been extended. Dr. Tavaria also stated the most significant cause of the miner's respiratory failure was pneumoconiosis. He agreed on cross-examination that emphysema was also present and that the miner's emphysema was due to his long history of cigarette smoking. He also agreed the x-ray reports indicated the presence of bullous emphysema. He further stated the miner's progressive lung disease, coal workers' pneumoconiosis, caused a general weakening of his condition. He also stated the miner would have died from pneumoconiosis and it is not clear to what extent the lung cancer hastened the miner's demise. Dr. Tavaria stated on further questioning that the miner's respiratory failure was not due to lung cancer but was due to pneumoconiosis (CX 5).

Dr. J. Hertz, a board certified pulmonary specialist, reviewed the records and issued a report dated July 11, 1999. Dr. Hertz stated the miner at his death had multiple diagnoses including severe chronic obstructive pulmonary disease, coal workers' pneumoconiosis, history of congestive heart failure, coronary artery disease with PTCA, hypertension, and old myocardial infarction. Dr. Hertz stated the miner carried these diagnoses for many years and was stable until September, 1998 when he was hospitalized with widespread and widely metastatic lung carcinoma with a large 4 centimeter right mass, extensive mediastinal adenopathy and lymph nodes encroaching and surrounding the right lung with multiple liver, spleen and adrenal metastasises. Based on the widespread and essentially terminal presentation, Dr. Hertz stated the metastatic lung cancer was the most significant cause of the miner's deterioration and death. Dr. Hertz further stated he did not believe the miner's coal workers' pneumoconiosis was a significant factor in contributing or hastening his death (DX 27). On September 9, 1999 at his deposition, Dr. Hertz stated the bullous emphysema present in this case was due to the miner's cigarette smoking history and it's effects on the miner's lung function. Dr. Hertz reiterated his opinion the miner's coal workers' pneumoconiosis was not a significantly contributing factor in the miner's death because the significant factor was his widespread terminal metastatic lung cancer. He further stated the miner would have died quickly from this cancer regardless of his other medical conditions and he noted that without the cancer, the other medical conditions were being well managed. Dr. Hertz agreed on cross examination the miner had severe lung disease due to emphysema, chronic obstructive pulmonary disease and coal workers' pneumoconiosis (DX 27).

On December 23, 2000, Dr. M. Sherman reviewed the medical evidence. Dr. Sherman noted the miner had a complicated medical history including cardiac tests which showed coronary artery disease, and congestive heart failure, elevated cholesterol, history of syncope in 1995, a history of carotid artery disease, hypothyroidism, latent syphilis,

repair of abdominal aortic aneurysm, possible seizure disorder, anemia, and right acetabular fracture in 1995. Dr. Sherman also noted a history of chronic obstructive pulmonary disease with emphysema and chronic bronchitis which was treated with bronchodilators. He noted Claimant's history of shortness of breath from 1996 on and his history of smoking from 1 to 2 packs of cigarettes a day until 1985. Dr. Sherman stated chest x-ray reports showed obstructive lung disease and pneumoconiosis in 1994 and the appearance of emphysema with large bullae in 1996. In 1998, chest x-ray reports showed no change in the pneumoconiosis present. Dr. Sherman further noted Dr. Ahluwalia's suspicion of lung cancer in 1996 which was, however, not shown on CT scans of the thorax at that time. He noted the CT scan did show extensive bullous emphysema. Dr. Sherman reviewed Claimant's medical treatment notes, hospitalization report and other medical evidence. He concluded, the miner did have severe emphysema and chronic obstructive pulmonary disease the etiology of which undoubtedly was a combination of the miner's coal dust exposure and long history of cigarette smoking. The miner's death was due to lung carcinoma with extensive metastatic disease to the liver, spleen and adrenal gland. Dr. Sherman agreed the severe chronic obstructive pulmonary disease present clearly had a significant impact on the miner's health and quality of life before he died. He stated however, pneumoconiosis was not a substantially contributing cause or factor leading to the miner's death since there is no association in the medical literature between coal dust inhalation and the development of cancer. The cause of the miner's death was lung cancer and not emphysema. Thus, Dr. Sherman concluded pneumoconiosis did not contribute to the miner's death but did contribute to his chronic shortness of breath and requirement for oxygen therapy prior to his death. Dr. Sherman then stated that if the tumor had been discovered earlier, the severity of the chronic obstructive pulmonary disease would have prevented effective treatment for the cancer, and in that circumstance, pneumoconiosis would have hastened his death because it would have prevented treatment which could have prolonged his life. However, such treatment could not be offered in the absence of early detection, thus, in this circumstance, pneumoconiosis did not hasten the miner's death due to lung cancer (DX 15).

Dr. Dittman, a board certified internist, reviewed the records on August 3, 2001 and reported the miner died due to carcinoma of the lung which was extensive within the thoracic cavity as well as metastatic beyond the thoracic cavity. The carcinoma was to such an advanced stage and extent that it alone was responsible for the miner's death. The carcinoma was of such severity it was not curable from any therapy. Dr. Dittman also stated that neither chronic obstructive pulmonary disease which was due to smoking nor coal workers' pneumoconiosis which was due to coal mine employment were the cause of them miner's carcinoma of the lungs. The coal workers' pneumoconiosis present did not cause, contribute to or hasten the miner's death (EX 1). At his deposition taken on October 5, 2001, Dr. Dittman stated the miner's emphysema was not related to coal mine employment but was related to his long history of cigarette smoking. He also noted the chest x-ray of September 19, 1998 made no mention of coal workers' pneumoconiosis or malignancy, but did note the presence of bullous emphysema. Dr. Dittman stated the

cancer was discovered in September, 1998 and was wide spread with no hope of recovery with surgery, radiation or other treatments. This cancer was fatal and nothing could be done to prolong the miner's life. Dr. Dittman stated further the carcinoma present was not related to the miner's coal mine employment or coal workers' pneumoconiosis and he stated such a conclusion is well supported by the medical literature. Thus, he agreed with the death certificate that the miner's death was due to respiratory failure due to lung cancer, but he did not agree the lung cancer was due to coal workers' pneumoconiosis (EX 2).

In addition to the medical records set forth above, the record also includes a packet of medical reports with handwritten notations by the miner's daughter which were submitted along with a congressional inquiry. These notations note Dr. Kleaveland's statement in February, 1997 that the miner's determination against a cardiac catherization was wise given his severe lung disease. In addition, the miner's daughter noted Dr. Ahluwalia stated in May, 1996, that if the miner had lung cancer, he may not be a candidate for therapy due to his poor pulmonary reserve. The miner's daughter also alleges in these notations the miner's bullae was due to silicosis and the miner's lung cancer was not diagnosed earlier because his severe lung disease and respiratory insufficiency made diagnostic studies impossible. The miner's daughter also stated that since he stopped smoking, the smoking related lung condition would not worsen, but the silicosis due to coal mine employment would continue to worsen. Finally, she noted discrepancies in the medical report of Dr. Hertz including his mistaken notation that the miner had hyperthyroidism rather than hypothyroidism. The miner's daughter also contended in these notations that the miner's heart damage was due to pneumoconiosis (DX 18).

While the miner's daughter raised many good and valid questions which will be considered in determining what weight to give the various medical reports, her assertion that the miner's bullae was due to silicosis is outweighed by the opinions of the physicians of record who attribute the miner's emphysema and bullae to his long history of smoking. Likewise, the daughter's statements that the miner's lung condition would not worsen from the effects of smoking once he ceased or that his heart disease was due to pneumoconiosis are not supported by any other medical reports or deposition testimony and are, therefore, accorded little weight. Finally, the miner's daughter's allegation that the miner's severe pulmonary disease prevented diagnosis of the lung cancer is not discussed anywhere else in the record. While lay evidence may be used to establish the miner's physical condition prior to his death in a case filed prior to January 1, 1982 where there is no medical or other relevant evidence addressing that issue [see 20 C.F.R. §725.204(c)(2)] survivors are not entitled to use lay evidence in establishing entitlement to survivor's benefits under 20 C.F.R. 718.205(c), the relevant regulation for this survivor's claim filed after January 1, 1982. Thus, the medical conclusions by a lay person, the miner's daughter, included in the handwritten notations in the congressional inquiry packet can not be the basis for any findings in this matter. It should be noted that even if the "lay

evidence" could be considered in claims filed after January 1, 1982, it would not be considered in this case since the record does include relevant medical evidence. However, as stated above, the inconsistences and errors in various medical reports highlighted by the handwritten notes will be considered in assessing what weight to give particular medical opinions.

Upon consideration of the medical evidence, I note that all physicians agreed that the miner was severely impacted by his pulmonary diagnoses prior to his death. The extensive medical reports and medical review repots clearly document that the miner's pulmonary diagnoses had affected his condition in the years prior to the final diagnosis of lung cancer. This includes reports of hospitalizations for exacerbation of chronic obstructive pulmonary disease, the x-ray reports of worsening bullae and emphysema, and the fact the miner was being treated with pulmonary medications as well as home oxygen. Most physicians also agreed the miner's death was due to the widely spread lung carcinoma first diagnosed just weeks before his death by CT scan. The physicians reports, however, disagree as to whether or not the severe pulmonary problems hastened the miner's death from lung cancer.

Dr. Tavaria, the miner's treating physician, stated at the deposition that it was his opinion the pneumoconiosis present was the most significant cause of the miner's respiratory failure and death. This is not consistent, however, with his own statements on the death certificate which lists the cause of death as lung cancer, nor in the final hospital records which clearly document treatment for extensive and metastatic lung cancer. Thus, I attribute little weight to his deposition statements that pneumoconiosis was the most significant cause of the respiratory failure since it is at odds with the hospital records and his own statement on the death certificate. There is no evidence, therefore, which establishes death due to pneumoconiosis under subsection 718.205(b)(1).

The evidence does, however, raise a question as to whether the miner' death was due to multiple causes including pneumoconiosis and it is not medically feasible to distinguish which disease caused death or the extent to which pneumoconiosis contributed to the cause of death. Dr. Tavaria's statements indicate it was his opinion the miner's pneumoconiosis contributed to his death since the miner's progressive lung disease weakened his condition. Dr. Tavaria also stated it was not clear to what extent the lung cancer hastened up the miner's demise. In contrast, however, Dr. Dittman and Dr. Sherman both agreed the miner died due to the widespread carcinoma which was not related to coal mine employment or to coal workers' pneumoconiosis. These physicians agreed the pneumoconiosis present as well as the extensive emphysema present significantly impacted the miner's pulmonary condition prior to his death. However, both physicians agreed the miner died due to carcinoma of the lung which was solely responsible for his death. Likewise, Dr. Hertz concluded the coal workers' pneumoconiosis was not a significant contributing factor in the miner's death which was due to metastatic lung cancer. While I agree upon review of Dr. Hertz's medical

statements that he incorrectly included a diagnosis of hyperthyroidism rather than hypothyroidism as noted by the miner's daughter, I also note he is highly qualified as a pulmonary specialist. His findings on the etiology of miner's pulmonary diagnoses, therefore, will be considered along with the other medical evidence of record. Dr. Hertz's findings on the miner's physical condition prior to his death will be accorded less weight since this is the area of his report which is based, in part, on incorrect diagnoses.

I have also considered Dr. Sherman's statement that if the tumor had been detected earlier, the miner's severe pulmonary condition would have prevented effective treatment and, thus, hastened his death. There is no evidence of record to establish that the pneumoconiosis present prevented an earlier detection of the fatal lung cancer. There is no evidence to show that the lung cancer could have been detected earlier and effectively treated. Dr. Dittman stated that there was no effective treatment which could have been offered to the miner for treatment of his lung cancer. He stated there was no medical treatment which could have prolonged the miner's life.

The reports of the physicians which conclude that the miner's death was due to the extensive metastatic lung cancer are well supported by the hospital records from the miner's final hospitalization in September, 1998. As noted above, Dr. Tavaria's statement that the miner died due to pneumoconiosis is not supported by the hospital records nor his own statements on the miner's death certificate. Under such circumstances, I accord less weight to Dr. Tavaria's findings regarding the cause of the miner's death and I accord great weight to the opinions of Drs. Dittman, Sherman and Hertz who all conclude the miner died due to metastatic lung cancer. Furthermore, the statements of Dr. Dittman, Sherman and Hertz that the development lung cancer was not related to the miner's pneumoconiosis are well supported by their references to medical authorities as well as their agreement on this important point.

Upon review of these reports, I find no basis for a finding that the miner's severe pulmonary condition hastened his death. Drs. Dittman and Sherman agreed that there was no effective treatment available for the fatal lung cancer. The speculative statements that this could have been treated if discovered earlier is not sufficient to support a finding that the pneumoconiosis present hastened the miner's death. In addition, while Dr. Sherman stated that pneumoconiosis would have prevented earlier effective treatment of lung cancer, the extensive hospital and treatment reports include more discussion and concern about the developing emphysema as opposed to pneumoconiosis. Thus, even if Dr. Sherman's statement that treatment would not have been possible even in the case of early detection due to the miner's pulmonary condition were sufficient to establish the miner's pulmonary condition hastened his death from lung cancer, the record as a whole does not support Dr. Sherman's statement that pneumoconiosis was the pulmonary condition which would have prevented such treatment. In addition, as noted above, this speculative statement is insufficient to establish that the miner's death was hastened by the pneumoconiosis.

Upon consideration of all the medical reports, I find the evidence is not sufficient to establish the miner died due to pneumoconiosis or anthracosilicosis. Furthermore, I find the evidence is not sufficient to establish that pneumoconiosis was a contributing cause or factor in the miner's death. The final hospital records indicate the miner's death was caused by carcinoma of the lung. There is no support in the record for Dr. Tavaria's inclusion of pneumoconiosis on the death certificate as a cause of the fatal lung cancer. Furthermore, the probative and persuasive medical evidence of record does not establish the pneumoconiosis present hastened the miner's death from lung cancer.

In black lung cases, the benefits claimant bears the burden of persuasion and not merely the burden of production of some favorable evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251 (1994). The probative and persuasive medical reports and statements do not establish that pneumoconiosis caused the miner's death as required by subsection 718.205(c)(1). In addition, they also fail to establish that pneumoconiosis was a substantially contributing factor as required by subsection 718.205(c)(2) nor do they establish that pneumoconiosis was a substantially contributing cause or hastened the miner's death as required by §718.205(c)(4) or (c)(5). Thus, I conclude Claimant has not established the miner's death was due to pneumoconiosis under the provisions of subsections 718.205(c)(1), (c)(2), (c)(4) or (c)(5).

The presumption included in §718.205(c)(3), is applicable only when large opacities or massive lesions are identified. Since neither large opacities nor massive lesions have been identified in this matter, subsection 718.205(c)(3) is not applicable to this claim. Accordingly, I find the medical evidence fails to establish the miner's death was due to pneumoconiosis under the provisions § 718.205(c) and, therefore, I find the widow is not entitled to survivor's benefits.

Attorney's Fee

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered to the Claimant in pursuit of this claim.

ORDER

The claim for survivor's benefits filed by Betty Wentz, widow of Joseph Wentz, is hereby **DENIED.**

A
PAUL H. TEITLER
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C. 20210.